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ABSTRACT

This paper discusses the characteristics of three community-based early childhood care and development support programs: the Community Mothers Program of Dublin, Ireland; the Maternal and Infant Health Outreach Workers Program of Tennessee; and the Mothers Inform Mothers Program of the Netherlands. The paper considers the general characteristics of successful programs, the method of peer group home visiting, the role of stakeholders of the program, program evaluation findings, the role of programs in the prevention of child abuse, and strengths and weaknesses of such programs. The paper concludes that these programs have a powerful potential for empowering parents. (Contains 20 references.) (JPB)

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Community based support programs and primary prevention

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Introduction

In several European countries there is nowadays a gap between the objectives of the child health care system - the promotion and safeguarding of a healthy, physical, mental and social development of the population of young children, starting from the parents personal responsibility, by means of influencing the relevant health determinants - and the health of different target groups of the population. The social groups with the lowest incomes, the lowest levels of education and the lowest occupational status are generally worst off when it comes to health (Mackenbach 1996, Schulpen 1996, Voorham & Van Haasdrecht 1996, Hermanns 1996). In addition it was felt that the working class parents experienced difficulty in communicating with the predominantly upper-middle class health care professionals. Communication problems did hamper these parents access to educational support and health education. Generally speaking, there are too many children in need and socio-economic health differences do exist in many western European countries, although health policy emphasises the reduction of inequalities in health.

Initiated by the Van Leer Foundation innovative programs have been developed to bridge this communication gap between professionals and the public, to promote health and to empower parents. Empowered parents may be able to influence their span of control, so their world becomes more manageable. To stimulate self-confidence and self-care management, to support deprived parents in their educational and care tasks new programs supporting child health care and child rearing have been developed. These programs located in local communities have been called "community-based early childhood care and development support programs". You will find these programs nowadays in the United Kingdom, Ireland, the Netherlands, Germany and other Western European countries, Australia and the United States of America (Hanrahan and Prinsen, 1997). Research indicates that the main benefit of these programs is in growing self-confidence and empowerment of parents, better self-care for parents and their children and increasing support. Stimulating these protective factors in health and education the support programs contribute to primary prevention. These kinds of programs might be part of the solution of preventing child abuse, like research of the Irish program indicates (Johnson, Howell and Molloy 1993).

The aims of community-based early childhood care and development support programs

The aims of the programs are to support young parents with parenting; helping them to cope, staying abreast of their child's development and preventing childrearing and health problems. The main goal is focused on mothers by trying to reinforce their sense of self-esteem and improve their ability to be independent parents. In doing so they, as the main educators, may increase the opportunities for optimal development and health for their children. Community-based support programs do not only seek to improve the effectiveness of anticipatory health education directed to parents from socio-economic disadvantaged groups, they are also directed towards refugees and displaced persons. The designers of the program wish to empower mothers. Simultaneously however, the program influences the organization of professional services provided.

Description of the programs

Community-based support programs have found their basic priciples in roots like the 'Health for all ' strategy of the World Health Organization or the primary health care philosophy, expressed at the Alma Ata conference in 1979. On the educational side, principles underlying these programs are based on the theories of Freire, Barker's *Child Development Programme* and Sameroff's theory of transactional regulation and early intervention. From the welfare point of view the community

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development and strategies on social exclusion and poverty had an important influence. A brief survey of these kinds of programs in Europe therefore shows some common characteristics based upon these principles.

Characteristics
All over the world community-based support programs - focused on child health caring, empowering parents and childrearing of very young children - express some typical characteristics. Nearly all of them can be described as home-based interventions with a pivotal role of mothers and a strong focus on mother-to-mother communication, social support and networking. One of the key values is empowerment. The mother is seen as the expert of her own child. The professional role is limited to guiding the mothers.
These kinds of programs are based on:
- a holistic approach,
- intregrating health care and child rearing,
- using the experience of parents together with professional knowledge,
- supporting individuals in a societal context,
- using methods of peer group education, home visiting and networking.

Method of peer group home visiting
To support and empower parents the programs start early, ideally just before confinement, and lasts until the baby is 18 or 24 months old. The inexperienced mother receives monthly visits in her own home. The health visitors, most of the time volunteers and experienced mothers, but sometimes professionals like community nurses, do come from the same target groups that they serve. They are well equipped to answer the questions that expectant and new mothers have. They also have an understanding of what the new mothers are going through. An experienced mother of twins for example is matched with an inexperienced mother of twins. Similar with mothers who breastfeed their babies, or mothers with a baby suffering from a severe allergy or born prematurely. The health vistors adapt the information to suit the individual mother they visit. Both live in the same neighbourhood and usually have similar backgrounds. The experienced mother will use her own standards and experiences as a mother to support and assist the young mother. In doing so she will give as little advice as possible. Rather she will support the young mother to find her own answers to day-to-day questions and solve problems when they arise. The program evolved is multicultural in approach and attitude and there are strong indications that the target groups are now being reached.

Stakeholders of the program
Local experienced mothers are prepared to support inexperienced mothers who are poor, stressed or feeling isolated and insecure about their infant's development. They help them to use their own knowledge and instincts in order to reduce health or other risks which may impair their baby's development. They volunteer their services but are paid their expenses. They liked to share their experiences with others, mainly because they felt the need for those services themselves when they were inexperienced. The mothers are the original stakeholders of the program. Important other stakeholders involved are the nurses or social workers as the coaches of the mothers, their collegues in the local network and management of community nursing and local health care organizations or welfare agencies. At the national or state level Health Boards, institutes on research and development of health and welfare or universities are participating.

Community-based support programs: experiences in the Western world

It is easy to present some examples of community-based support programs. A brief description is given now of three of these programs:
- the *Community Mothers Program* from Dublin, Ireland;
- the *Maternal and Infant Health Outreach Workers Program* from Tennessee USA;
- the *Mothers Inform Mothers Program* from the Netherlands.

The Community Mothers Program Dublin
In the last two decades many community-based support programs have been developed in the Western world. Most of the community-based support programs are innovations of the original *Child*

Development Programme (Barker, 1992). This is an international parent support program in which health visitors carry out structured home visits to foster parenting skills and the mothers self-esteem. A first innovation has been made since 1988 in Dublin, Ireland. Formally started at the Eastern Health Board the Irish developed the *Community Mothers Program* (Molloy 1996). This is an support intervention program involving lay people, aimed at improving the quality of parenting during the first two years of life. The target group consisted of parents of children living in working class communities. Nowadays 160 experienced mothers deliver a program focusing on health care, nutritional improvement and overall child development to more than 1000 new parents, facilitated by 10 family development nurses. Support, encouragement and guidance are used rather than advice. Using a randomised control approach the program was evaluated and found to be effective in terms of health, nutrition and developmental stimulation (Johnson, Howell & Molloy, 1993). It has now expanded to incorporate breastfeeding support, parent and toddler groups and attention to the special needs of travellers.

The Maternal and Infant Health Outreach Worker Program
A typical example of a community-based support programma in the United States of America is the *Maternal and Infant Health Outreach Worker Program* (MIHOW). This program draws on the strength inherent in rural communities as well, primarily the heart and spirit of local people. The program's goal is to enhance the lives of disadvantaged children. Rural children are among the most disadvantaged. They live in the poorest regions and the ones most neglected by mainstream America. Unemployment is high, and medical and social services are inadequate or inaccessible. Yet despite severe financial hardships and lack of services, many rural people - parents, children, and workers - remain optimistic about the future. These people are the heart of the MIHOW project.

MIHOW is a community-based intervention aimed at improving health and child development in the Appalachian Mountains and the Mississippi Delta regions. Sponsored by Vanderbilt University in Tennessee, each MIHOW project is also sponsored by a local agency. There are 17 such MIHOW sites at present. Local mothers who are known and trusted in their communities are recruited by the local sponsoring agency, are trained by the program, and become paid paraprofessional home visitors. They visit low-income, high-risk pregnant women and families with young children in their homes, before and after childbirth, providing health and child development education, support for healthy lifestyles and positive parenting practices, and help in gaining access to health and social services. Parenting groups give parents an opportunity to share experiences and learn from each other.
MIHOW begins with the goal of improved infant and maternal health, but it does not end there. The empowerment of individuals, families, and communities can lead to long-term, sustainable responses to serious inadequacies in social services.
Local agencies or clinics decide the specific methods and direction for their own programs within the MIHOW framework. Building on a history of organizing and self-help in these communities, paraprofessional outreach workers provide peer support, links to existing health and social services, and pre- and perinatal health information to rural families. In addition to the families, the outreach workers become empowered to grow and improve their own lives. In these ways, the entire community benefits as a result of MIHOW.

Evaluations of the program reveal impact in several areas of concern to MIHOW's stakeholders. In a study of the MIHOW project sponsored by the Ford Foundation (Clinton, 1992), findings showed that MIHOW participants, compared to a control group:
- consumed more vitamins and iron, and less tobacco and caffeine, during pregnancy;
- received more prenatal medical visits; and
- were more likely to breast-feed (33.3%, compared to 22.5%).

In a qualitative study (Clinton, 1990) sponsored by the Bernard van Leer Foundation, almost all of the participants said they had learned more about health as a result of their participation.
Participation in MIHOW has been shown to affect positively the development of children whose mothers are enrolled in the program. In focus groups and interviews, several mothers noted their children's progress in verbal, reading, and social skills while participating in MIHOW.
Mothers who have participated in MIHOW learn and grow in a variety of ways, both within the family and beyond. Participants in the study also said their sense of purpose and hope for the future had improved as a result of their participation in MIHOW. Many also gave examples of improved

decision-making on family planning that they attributed to the program's influence (Clinton, 1990). The program enhanced empowerment of the participating mothers and their citizenship (Maloney, 1995; Maloney, Skaggs and Clinton, 1996). The percentage of MIHOW participants who said they knew how to help themselves or someone they know in acquiring community resources was significantly higher than non-participants for services like affordable medical care (81% to 62%), well-baby medical services (98% to 72%), assistance with alcoholism, drug abuse, or depression (72% to 46%) and for support groups (42% to 22%).
Many participants and former participants serve on committees, advisory boards, or boards of directors of the local MIHOW sponsoring agencies. They have been partners with site staff and others in initiating and developing such community programs as parenting education, child care centers, family planning, child abuse prevention and job training. These findings confirm the earlier findings that demonstrated that MIHOW had a powerful and positive impact on the participating families, on the women providing the services, on the leaders managing local programs, and on the local organizations sponsoring the intervention.

Other examples of community-based support programs like MIHOW and the Dublin Community Mothers are the *Parent to parent support programs* in Wales and the *Parent support programs* in Cork, Limerick and other cities in Ireland. Similar to these kind of programs is a home visiting support program like *Home Start*, a voluntary family support program in England, the Netherlands and other countries. In the field of health education and mental health promotion one is using a comparable method in fellow patient support programs or mutual support programs. The third and final description of a community-based support program is the so called *Mothers inform mothers program*, located in the Netherlands.

The Dutch Mothers inform mothers (MIM) program

MIM is an innovative Dutch Early Child Care and Development Program. The program is developed as a part of the regular health services for parents and babies aged 0 to 18 months. It is a community-based preventive program which is focused on healthy individual behaviour of young mothers. The locus of responsibility is the individual mother and her baby. The mother is regarded as having ultimate responsibility for her objective health status and she is indirectly responsible for the health and development of her baby. All mothers of first children are offered the program but special attention is given to reach socially disadvantaged groups, members of migrant communities and children in need (Hanrahan, Prinsen and De Graaf, 1996). Children in need are defined as those with disabilities and those whose health or development, in the broadest sense, would be impaired or limited without the provision of such services. MIM uses experienced mothers to help to provide educational support for new parents in learning effective primary health and educational practices. These mothers use inexpensivly produced cartoons depicting different scenes, or with choices that can be made about a specific topic. A discussion about the contents of a cartoon may act as a start for exploring the mothers attitude, knowledge or behaviour in relation to the advice she has received from different sources. The program also supports the aim to enhance the ability of women to cope with their newborn baby, to encourage them to adapt their behaviour after receiving health educational information, and to help to stimulate for instance to increase the number of women breast feeding, or to make women feel in control of their life. To help to plan their visits the experienced mothers use a discussion paper which they are free to use during the visit, or which they use to document their visit afterwards. The inexperienced mother will receive this document at the next visit. Thus the inexperienced mother has a record of all developments that take place during the eighteen months of the program.
MIM consists of a network of local programs in four towns, all carried out in deprived areas. MIM is a partnership between local communities, regional community nursing agencies and supported and nationally co-ordinated by the Netherlands Institute of Care and Welfare. Today 87 experienced mothers are visiting 216 mothers of newborn babies in the cities of Breda, Dordrecht, Uden and Sneek. Six community nurses of local agencies are coaching these visiting mothers.

Evaluation of MIM
Action research was carried out simultaneously with the developmental phase of the program (Wolf 1995). The results indicated that inexperienced mothers showed increased self-confidence and more

attention for the development of their child. They felt more independent and were better able to make their own choices. Mothers of different social backgrounds benefitted from the program.
Some inexperienced mothers stated that the program caused them to change their way they treated their children rather more than they had imagined before starting with MIM. The systematic attention for the development of the baby made mothers more sensitive to the incremental steps in many areas at which the child's development takes place. The mothers themselves spoke of being 'more aware' and 'giving things more thought'. The program tools, together with the monthly recurring topics discussed seem to have made mothers more 'active' with regard to their children's upbringing. Several mothers said that they 'paid more attention' to the incremental developmental steps of their baby. This could conceivably have a positive effect on sensitivity and responsiveness within the parent-child relationship.

The experienced mother proved to be an answer to the two problems which had given rise to the start of MIM: lack of receptivity and insecurity about childrearing. There is evidence of increased 'empowerment' amongst both program and experienced mothers. A clear understanding of the range and type of questions from parents to the experienced mothers has influenced practices at well-baby clinics. As far as the experienced mothers were concerned, their increased self-sufficiency manifested itself in the fact that they became more active in social activities (other voluntary activities, new educational opportunities, employment) within and outside the program. This is in line with results from the United Kingdom and Ireland that also show indications that visiting mothers are progressing to paid employment or that they go back to school to continue their education.
Interviews with health visitors and social paediatricians revealed that long-term association with the program had made them increasingly convinced of the advantages of approaching mothers as experts on their own children. The advantages of an alternative professional attitude had gained increased recognition. This leads me to the conclusion that if members of the target groups are seen as active participants this will change the role and position of an expert and create a better intervention climate.

Community-based support programs and the prevention of child abuse

The main contribution of community-based support programs to the prevention of child abuse is identified in the developing self-confidence of mothers and their educational span of control. As Hanrahan (1996) stated: "*These programs may contribute to the prevention of child abuse, because at a very early stage mothers learn to express their feelings and emotions of inability in childrearing. And they learn to manage such feelings of inability and incompetence*". In the long run there is a perspective of better health of the children, at least with regard to some health determinants like breastfeeding, accidents and nutrition. The increasing experience of support is another protective factor contributing to primary prevention.
Specifically to the prevention of child abuse there is some evidence of benefits from the community-based support programs. Johnson, Howell and Molloy reported (1993) that "*mothers in the intervention group were less likely to be tired, feel miserable and want to stay indoors; they had more positive feelings and were less likely to display negative feelings*". Although they did not find a significance in the cases of child abuse - no case in the intervention group against three in the control group - the results were compatible to the findings of a 50% reduction of child abuse in the Belfast program (Barker, Anderson & Chalmers, 1987). Olds (1986, 1990) reported from the United States also a reduction of child abuse for similar programs with nurse home visitation.
Nevertheless, all this research may be regarded as no more than a small indication of the contribution of community support programs to the goals of prevention of child abuse. It is necessary to do more community-based research trials to prove the effectiveness of these programs. It is time to start transnational research.

Innovation and perspectives

Community-based support programs in the field of health promotion or childrearing support may be contributing to primary prevention. Discussing these programs we have identified the main strengths of these programs as:

* developed in partnership with the target groups (disadvantaged mothers);
* developed as a potential integral part of the child health service;
* their potential reach towards target groups is high;
* using a holistic, ecological and parent-oriented approach
* research and the results of the process evaluations are encouraging;
* potential effect lowering social-economical health differences seems to be present;
* the program intervenes and interacts with mother/baby's health and welfare, including the prevention of child abuse.

There are also a few weaknesses and problems to overcome to get the program integrated in the preventive child health package:
* only small scientifically proven effects on the health of mothers and babies concerning early child care and development programs are available (Olds 1990, Johnson, Howell & Molloy 1993).
* no study on the cost-effectiveness of the program has been carried out. Donalson proposes to use a framework for using economics in health care settings within a framework known as program budgeting and marginal analysis (Donalson, 1995).
* a discussion on the positioning of the program within preventive child health care or welfare agencies is in progress.
* the financial basis for the program within current budgets of health care or welfare agencies is difficult; programs have to compete with many other projects and activities.
* reaching mothers living in multi-problem circumstances is slow and time consuming and achieving results within a relatively short time is difficult.

My conclusion is that community-based support programs have a powerful potential on empowering parents. The results are encouraging so far. Offered as a global program of supporting child development and child care, these kind of programs have the power to serve the prevention of child abuse when the program is specifically targetted to this goal.

References

Barker, W., R. Anderson & C. Chalmers. 1987. *Early health and development evaluation document 11. Belfast: preliminary findings on the result of the Child Development Programme*. University of Bristol / Eastern Health and Social Services Board, Belfast.
Barker, W. 1992. *Child protection: the impact of the Child Development Programme*. Early Childhood Development Unit, School of Applied Social Studies, University of Bristol.
Clinton, B. 1990. *Against the Odds: Parenting in Disadvantaged Communities*. Report to the Bernard van Leer Foundation.
Clinton, B. 1992. *The Maternal Infant Health Outreach Worker project: Appalachian communities help their own*. In: Mary Larner, Robert Halpern, and Oscar Harkavy (ed). Fair Start for Children: Lessons Learned From Seven Demonstration Projects. New Haven, Yale University Press.
Donalson C., Economics, public health and health care purchasing: reinventing the wheel? *Health Policy*, 33 (1995) pp 79-90.
Hanrahan, M. 1996. Moeders informeren moeders: de moeder als expert. In: *VKM Magazine*, juni, pp. 4-5.
Hanrahan, M.H. & B. Prinsen (eds). 1997. *Community health, community care, community support. Proceedings of the invitational conference on childhood care and development support programs*. Netherlands Institute for Care and Welfare, Utrecht.
Hanrahan, M., B. Prinsen & Y. de Graaf 1996. *Moeders kunnen veel meer*. NIZW, Utrecht
Hermanns, J. 1995. *Opvoedingsondersteuning: een poging tot wetenschappelijke en maatschappelijke legitimering*. In Haerden H. & Janssen D. (red). Pedagogische preventie: een antwoord op kansarmoede?. Garant, Leuven/Apeldoorn.
Johnson, Z., F. Howell & B. Molloy. 1993. 'Community mothers' programme: randomised controlled trail of non-professional intervention in parenting. *British Medical Journal*, vol. 306, 29, pp 1449-1452.
Mackenbach, J.P. 1996. *Migranten, migratie en volksgezondheid*. In: Haveman & Uniken Venema (red), Migranten en gezondheidszorg, Reeks gezondheidsbeleid deel 10, pp. 30 - 42, Bohn Stafleu Van Loghem, Houten.
Maloney, E., Skaggs, K., Clinton, B. 1996. *The Maternal Infant Health Outreach Worker project: The*

impact of peer support on health behavior and child development. Report to the Bernard van Leer Foundation.
Maloney, E. 1995. *Evaluating Empowerment of Women in the Maternal Infant Health Outreach Worker (MIHOW) Home Visiting Project in Rural Appalachia*. Report to the Bernard van Leer Foundation.
Molloy, B. 1996. *The community mothers program of the Eastern Health Board Ireland*. In: Children first; working paper of the invitational conference on health education for disadvantaged parents. Netherlands Institute for Care and Welfare and the MIM Co-operative, Utrecht.
Olds, D.L, C. Henderson, R. Tatelbaum & R. Chamberlain. 1986. Preventing Child abuse and neglect: A randomized trail of nurse home visitation. *Peadiactrics*, 78, pp. 65-77.
Olds, D.L. & H. Kitzman. 1990. Can home visitation improve the health of women and children at environmental risk? *Paediatrics*, vol. 86, nr. 1, pp. 108-116.
Schulpen, R.W.J. (red). 1996. *Mortaliteitsverschillen tussen allochtone en autochtone kinderen in Nederland*. Centre for migration and health care, Utrecht.
Voorham, A.J.J., & P.M. van Haasdrecht. 1996. *Gezondheidsbevordering: gekleurde samenleving, motor voor voorlichting*. In: Haveman & Uniken Venema (red), Migranten en gezondheidszorg, Reeks gezondheidsbeleid deel 10, pp. 43 - 61, Bohn Stafleu Van Loghem, Houten.
Wolf, E.J.R.M.. 1995. *Met steun van een moeder: actiebegeleidend onderzoek van het programma Moeders informeren moeders*. Nederlands Instituut voor Zorg en Welzijn, Utrecht.